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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/04/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cognitive rehabilitation program 80 hours/units initial trial-outpatient

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for cognitive rehabilitation program 80 hours/units initial trial-outpatient in this case has not been established.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx when he slipped and fell striking his head on concrete. The patient was assessed with a post-concussive syndrome. Prior conservative treatment did include individual psychotherapy through 10/16/14 for which the patient was noted to be responsive to treatment. The patient's functional capacity evaluation from 11/03/14 noted the patient was functioning at a sedentary to light physical demand level but his job required a very heavy physical demand level. The most recent psychological evaluation from 11/26/14 noted psychological and cognitive deficits. Prior medication use was pertinent for muscle relaxers, analgesics such as Tramadol and Tylenol 3, and other unrelated medications. The patient was recommended for an initial 80 hours of a cognitive rehabilitation program. This was previously denied on 12/12/14 and 01/09/15 as the clinical documentation did not identify exhaustion of all modalities in treating the patient's post-concussive syndrome. There was also a lack of documentation establishing that the patient had made any prior substantial improvement with cognitive behavioral therapy provided up to 11/26/14.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for continuing cognitive and psychological deficits stemming from a concussion injury in April of 2014. The patient has been previously treated with individual psychotherapy and medications for pain. There is a noted functional deficit based on a functional capacity evaluation. The patient is noted to have responded appropriately to individual psychotherapy through October of 2014. In review of the clinical documentation submitted, it does not appear that the patient has reasonably exhausted all lower levels of care before considering a cognitive rehabilitation program. The patient was doing well with individual psychotherapy and there was no indication that trials of psychotropic medications have been performed to

date. Given the lack of documentation regarding failure of all lower levels of care, it is this reviewer's opinion that medical necessity for cognitive rehabilitation program 80 hours/units initial trial-outpatient in this case has not been established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)